the acini of which are distended with colloid material. There are also numerous areas of pigmentation from old hæmorrhages, and many extensive recent hæmorrhages, together with many extensive areas of small round cells of inflammation.

Dr. Powers said that there exists in the fœtus a duct between the thyroid gland and the foramen cæcum, and along the course of this duct (thyro-lingual) in the adult thyroid-gland tissue is occasionally found.

Butlin had found in two cases that partial removal hastened growth of the remaining part, then it again diminished in size. In the case which he had reported the second tumor doubtless occurred in some thyroidal tissue which had been overlooked at the first operation and which afterwards grew rapidly. Similar cases have been reported by Wolff, Bernays, and others, but there appear to be very few recorded.

Stated Meeting, March 28, 1894.

The President, ROBERT ABBE, M.D., in the Chair.

MECHANICAL APPLIANCE FOR CORRECTION OF DEFECT AFTER REMOVAL OF HALF OF THE LOWER JAW.

DR. CHARLES MCBURNEY presented two patients illustrating the use of a mechanical appliance to correct defect after removal of half of the lower jaw. (See page 35.)

RESECTION OF VESICAL END OF URETER FOR TUMOR OF BLADDER.

DR. WILLY MEYER presented a patient, a man forty-three years of age, who first experienced trouble in passing water at the beginning of 1891. His chief complaint then was of continuous pain while making water and slight tenesmus at the end; the last drops were pure blood. He had been treated almost a year and a half for catarrh of the bladder and inflammation of the prostate when he came under Dr. Meyer's observation. At this time he was able to pass water easily, in a good stream; no blood, but a kind of milky fluid at the

end. The prostate was not enlarged. It was slightly painful on pressure. The bladder easily held a pint of water.

Cystoscopy was performed, and Dr. Meyer was not much astonished, in view of the history, especially the passage of pure blood at the end of micturition, to find a tumor of the bladder, but he was surprised to find so large a one. The cystoscope could be pushed back towards the fundus for fully two inches, and still the tumor was visible. The mouth of the left ureter could easily be seen. That of the right one was invisible. From the left ureter came perfectly clear urine. At one side of the tumor near where the right ureter should enter the bladder, a small amount of turbid fluid escaped at intervals. It was concluded that the tumor involved and compressed the ureter, and had probably led to pyelitis.

Suprapubic cystotomy was done February 16, 1893, the transverse incision being employed as was his custom. As soon as the bladder was opened, the same condition was seen as with the cystoscope. A tumor of apple size came into view. The mouth of the left ureter was readily distinguished, while that of the right was invisible. The tumor was partly shelled out and partly cut out, employing the Paquelin cautery and scissors. The patient made a good recovery, and when presented appeared in excellent health.

Examination of the tumor showed that two inches of the lower end of the ureter, in fact the entire part of it that traversed the bladder-wall obliquely, had been excised with it. It formed a part of the large basis of the tumor. Dr. Meyer had expected subsequent occlusion, or at least cicatricial constriction of the divided ureter to take place after a time, but fortunately it had not. A tumor is not palpable in the right lumbar region to-day. Cystoscopy performed again seven months after the operation showed a large scar at the site of the excision, and escape of urine out of an oval-shaped, irregular hole in about the centre of the scar. The urine, however, was purulent, and confirmed the original diagnosis of pyelitis. The abdominal wound had been allowed to heal by granulation, which left in these cases a scar less liable to the occurrence of hernia, he thought, than where stitches were introduced and primary union of the skin obtained throughout.

DISARTICULATION AT THE HIP BY JOURDAN'S METHOD.

Dr. R. Abbe presented a woman illustrating the admirable result of the Jourdan method of amputation at the hip, but also showing

the difficulty instrument-makers found in fitting a serviceable limb in many such cases. The fleshy stump, the bone having been shelled out, was the longest that could be made by that method, was muscular and entirely under the control of the patient, but the artificial limb made for her had caused too much pain for use. The operation had been done for sarcoma of the lower end of the femur one year before.

OLD DISPLACEMENTS OF THE UPPER END OF THE FEMUR, AND THEIR TREATMENT.

DR. CHARLES T. POORE read a paper with the above title. (See page 27.)

DR. C. MCBURNEY said with regard to congenital dislocation of the femur that operative measures offered no hope of forming an acetabulum in which the head of the femur could be retained. He had operated in two cases, but the head of the femur slipped out as soon as the fixation apparatus was removed. The patients acquired use by experience, which surpassed any that could be offered by operation or mechanical appliance.

DR. VIRGIL P. GIBNEY had not understood the reader to mention any cases of congenital dislocation of the hip, rather those only of accidental displacement, and to them he thought his remarks were very pertinent. In no case of accidental displacement during the course of disease, as during confinement to bed for some time on account of deformity, had he succeeded by operative measures in permanently retaining the limb in the corrected position. As the author had stated, after the lapse of two or three years the head of the femur was found again out of place. He agreed with Dr. Poore, that if anything was done it was best to resect the head of the bone and not attempt to hold it in place. This was the rule. He had some exceptional cases,—cases which he hoped soon to present before the Society,—in which he had obtained excellent results.

The members would recall a case presented about a year ago by Dr. Gerster, a boy who had sustained dislocation at the hip-joint which had been reduced by the bloody method. There was also paralysis of the perineal group of muscles. This boy had drifted into the Hospital for Ruptured and Crippled a few months later, when Dr. Gibney cut down in the old scar left by Dr. Gerster's operation and found the head of the femur displaced. He scraped out the acetabulum again, took precaution to get a little deeper socket, replaced the femur, and held it in the corrected position. After a long

process of suppuration, healing took place, and the boy the past eight months had had the limb in good position. There was no shortening. The patient had since been undergoing treatment for the peripheral paralysis.

Dr. Gibney also mentioned a case of "flail hip," similar to one of the cases reported by Dr. Poore, which he had not published because it was too early to speak of the ultimate result. The boy was six years of age; the "flail hip" had resulted from an acute arthritis during childhood; the headless femur could be felt under the gluteal muscles; the shortening in this position amounted to two or three inches. Dr. Gibney cut down and chipped out two exostoses filling the acetabulum, replaced the headless end of the femur, left the dressing on eight or nine weeks, got good union, withdrew the nails and curetted their tracks. A small abscess formed in one of these, which made it necessary to replace the dressing for several weeks. At a recent examination a strong joint was found; there was not more than an inch shortening. Whether "flail hip" would develop again after two or three years he was unable to say.

Regarding congenital dislocation at the hip mentioned by Dr. McBurney, Dr. Gibney said that last fall, when in Würzburg, he had opportunity to see some of Dr. Hoffa's cases, six or eight in number, which had been operated upon from six weeks to a year before, and the results seemed surprisingly good. Dr. Hoffa had seemed to have little trouble in making an acetabulum and holding the femur in place, but he operated upon cases not more than five or six years of age. After the fifth or sixth week various passive movements were begun. Dr. Gibney had not yet obtained quite so good results from this method.

Dr. B. F. Curtis related a case of pathological dislocation successfully reduced by operation. A boy of seven or eight years was brought to St. Luke's Hospital with a history of having been ill two or three weeks with a large hip abscess. He was operated upon and the head of the femur resected. Two or three weeks afterwards the other hip suddenly filled with a large abscess, and the head of the femur slipped out upon the dorsum ilii. When Dr. Curtis cut down upon the joint, letting out about half a pint of pus, he was surprised to find no evidence of bone-disease. He replaced the head of the femur in the acetabulum, and put on an extension apparatus. The wound healed rapidly, the bone remained in place, and after several weeks a movable joint was obtained. The joint first diseased healed by ankylosis.

SPECIMEN OF ANTHRAX BACILLUS.

DR. R. ABBE presented specimens of anthrax rods and spores under the microscope, and also photographs of the patient, a man who had been brought to St. Luke's Hospital the week before with a spot on the neck beneath the right jaw, about an inch in diameter, which looked like an ill vaccination-mark. It was a raised, hard patch of purple-brown, surrounded by a row of vesicles; outside of that was œdema two and a half by three inches wide, and cellulitis running up under the chin and down on the chest to the nipples. Even a serious vaccination would hardly account for the condition, so that anthrax was at once suspected, and the bacilli in quantity were found in serum taken from the vesicles. The sore had begun as a pimple upon the neck which was cut by the razor while shaving, three days before admission, and from that time it had grown worse. The patient showed considerable depression: temperature 103¾° F., pulse only 80. As soon as possible the central area, including all the œdematous portion, was excised, but it was impossible on account of its extent to remove all the affected cellular tissue. The wound was packed with iodoform gauze. Two long incisions were also made through the cellular tissue and packed with gauze. The temperature fell at once to nearly normal, and there was such improvement by the next morning that it was supposed the man would recover. The following night, however, there was a change, the temperature slowly rose to 102° F., twenty-four hours after operation, and five hours later delirium set in, active delirium followed rapidly by a typhoid state with coma and high temperature, reaching 106½° F. The man died forty hours after excision. At the time of the operation cultures from the blood at the margin of the cellulitis, ten inches from the infection, showed anthrax, and blood from a prick of the finger also revealed bacilli. Before death blood from the finger was found swarming with anthrax. The case showed that it was not always possible to check the disease by excision of the infected area, although it had been done in a number of recorded cases.

DR. W. W. VAN ARSDALE said that a very simple method of making the diagnosis of anthrax where the bacilli could not be found in or about the pustule was to inoculate mice with a drop of the serum from it. When house-surgeon he had applied this method successfully in three cases. The patients were let alone, no operation was performed, and all recovered. It had been recently shown that pus was destructive of anthrax bacilli, and it seemed to Dr. Van Arsdale that

it was a better and simpler method to cure the patient by letting the sore go on to suppurate and thereby destroy the anthrax bacilli than to inject corrosive sublimate solution around the diseased area or to make incisions, and by these methods risk further inoculation of the disease-germs.

DR. JOHN A. WYETH mentioned a recent case which he believed to be one of malignant pustule, although the diagnosis was not confirmed by examination for anthrax bacilli. It began as a short scratch on the face about ten hours before he saw the patient. Pain developed, the lymphatics enlarged just in front of the ear, the man had a chill, and all the symptoms of rapid infection ensued. Dr. Wyeth cocainized the parts, made free incisions, injected a solution of bichloride (1 : 3000) through the whole cheek, and applied a poultice of flaxseed moistened with bichloride solution (1 : 5000); the relief was almost immediate. The diseased area sloughed out and the patient was practically well in five days. Dr. Wyeth thought it good treatment to inject a solution of bichloride to kill the disease-germs; but in order to insure success he thought it essential to see the case in the first few hours of infection.